		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046060

Facility Name: Eastview Terrace

Address: Eastview Place (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-7367 **Fax #** (217) 728-8405

IDPA ID Number: 371346306003

Date of Initial License for Current Owners: 02/01/00

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,223	2,175	1,681	20,079	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,223	2,175	1,681	20,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.32%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Yes - Meals for Inmates

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,681

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,711	13,913	1,214	158,838		158,838	140	158,978			1
2	Food Purchase		106,746		106,746		106,746	(33,370)	73,376			2
3	Housekeeping	45,401	18,093		63,494		63,494		63,494			3
4	Laundry	32,357	11,393		43,750		43,750		43,750			4
5	Heat and Other Utilities			54,051	54,051		54,051	380	54,431			5
6	Maintenance	24,782	23,145	10,248	58,175		58,175	2,254	60,429			6
7	Other (specify):*											7
8	**TOTAL General Services**	246,251	173,290	65,513	485,054		485,054	(30,596)	454,458			8
	B. Health Care and Programs											
9	Medical Director			14,250	14,250		14,250		14,250			9
10	Nursing and Medical Records	567,243	61,133	3,275	631,651		631,651		631,651			10
10a	Therapy		1,888	159,899	161,787		161,787		161,787			10a
11	Activities	18,205	1,627		19,832		19,832		19,832			11
12	Social Services		37		37		37		37			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	585,448	64,685	177,424	827,557		827,557		827,557			16
	C. General Administration											
17	Administrative	78,795		68,884	147,679		147,679	(68,884)	78,795			17
18	Directors Fees											18
19	Professional Services			17,060	17,060		17,060	8,915	25,975			19
20	Dues, Fees, Subscriptions & Promotions			3,887	3,887		3,887	194	4,081			20
21	Clerical & General Office Expenses	37,915	4,395	11,994	54,304		54,304	6,866	61,170			21
22	Employee Benefits & Payroll Taxes			141,859	141,859		141,859	11,045	152,904			22
23	Inservice Training & Education			2,455	2,455		2,455	276	2,731			23
24	Travel and Seminar			3,061	3,061		3,061	939	4,000			24
25	Other Admin. Staff Transportation			2,963	2,963		2,963	999	3,962			25
26	Insurance-Prop.Liab.Malpractice			46,143	46,143		46,143	487	46,630			26
27	Other (specify):*											27
28	**TOTAL General Administration**	116,710	4,395	298,306	419,411		419,411	(39,163)	380,248			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	948,409	242,370	541,243	1,732,022		1,732,022	(69,759)	1,662,263			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Eastview Terrace #0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			84,722	84,722		84,722	394	85,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,174	111,174		111,174	10,795	121,969			32
33	Real Estate Taxes			10,859	10,859		10,859		10,859			33
34	Rent-Facility & Grounds							1,811	1,811			34
35	Rent-Equipment & Vehicles			2,575	2,575		2,575	355	2,930			35
36	Other (specify):*											36
37	**TOTAL Ownership**			209,330	209,330		209,330	13,355	222,685			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,547		30,547		30,547		30,547			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,828	34,828		34,828		34,828			42
43	Other (specify):* Nonallowable Costs			19,838	19,838		19,838	(19,838)				43
44	**TOTAL Special Cost Centers**		30,547	54,666	85,213		85,213	(19,838)	65,375			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	948,409	272,917	805,239	2,026,565		2,026,565	(76,242)	1,950,323			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,576)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,196)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,734)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(222)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(450)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14)	43		24
25	Fund Raising, Advertising and Promotional	(6,426)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(40,004)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,622)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(21,620)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (21,620)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (76,242)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace

ID# 0046060

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Eastview Terrace
PROVIDER # 0046060
12/31/2003

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Offset Miscellaneous Income	(5,177)	2
Offset Miscellaneous Income	(3,650)	21
Miscellaneous - Part A	(2,750)	43
Special events	(2,652)	43
Labs - Part A	(3,314)	43
X-rays - Part A	(1,646)	43
Resident Promotions	(109)	43
Deferred Maintenance	637	6
Offset Meals on Wheels Income	(25,617)	2
Amortization of Loan Costs	4,333	32
Vending Machine Expense	(59)	43
Total	**(40,004)**	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Eastview Terrace # 0046060 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	140	0	0	0	0	0	0	0	0	0	140	1
2	Food Purchase	(2,576)	0	0	0	0	0	0	0	0	0	0	(2,576)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	380	0	0	0	0	0	0	0	0	0	380	5
6	Maintenance	0	1,617	0	0	0	0	0	0	0	0	0	1,617	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,576)	2,137	0	0	0	0	0	0	0	0	0	(439)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(68,884)	0	0	0	0	0	0	0	0	0	(68,884)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,915	0	0	0	0	0	0	0	0	0	8,915	19
20	Fees, Subscriptions & Promotions	0	194	0	0	0	0	0	0	0	0	0	194	20
21	Clerical & General Office Expenses	0	10,516	0	0	0	0	0	0	0	0	0	10,516	21
22	Employee Benefits & Payroll Taxes	0	11,045	0	0	0	0	0	0	0	0	0	11,045	22
23	Inservice Training & Education	0	276	0	0	0	0	0	0	0	0	0	276	23
24	Travel and Seminar	0	939	0	0	0	0	0	0	0	0	0	939	24
25	Other Admin. Staff Transportation	0	999	0	0	0	0	0	0	0	0	0	999	25
26	Insurance-Prop.Liab.Malpractice	0	487	0	0	0	0	0	0	0	0	0	487	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(35,513)	0	0	0	0	0	0	0	0	0	(35,513)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,576)	(33,376)	0	0	0	0	0	0	0	0	0	(35,952)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eastview Terrace # 0046060 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,734)	3,128	0	0	0	0	0	0	0	0	0	394	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	6,462	0	0	0	0	0	0	0	0	6,462	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,811	0	0	0	0	0	0	0	0	1,811	34
35	Rent-Equipment & Vehicles	0	0	355	0	0	0	0	0	0	0	0	355	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,734)	3,128	8,628	0	0	0	0	0	0	0	0	9,022	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,308)	0	0	0	0	0	0	0	0	0	0	(9,308)	43
44	**TOTAL Special Cost Centers**	(9,308)	0	0	0	0	0	0	0	0	0	0	(9,308)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,618)	(30,248)	8,628	0	0	0	0	0	0	0	0	(36,238)	45

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 140	$ 140	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	380	380	2
3	V	6	Maintenance supplies		Petersen Health Care Companies	0.00%	1,617	1,617	3
4	V	17	Administrative	68,884	Petersen Health Care Companies	0.00%		(68,884)	4
5	V	19	Professional services		Petersen Health Care Companies	0.00%	8,915	8,915	5
6	V	20	Dues, fees & subscriptions		Petersen Health Care Companies	0.00%	194	194	6
7	V	21	Clerical & general office		Petersen Health Care Companies	0.00%	10,516	10,516	7
8	V	22	Employee benefits		Petersen Health Care Companies	0.00%	11,045	11,045	8
9	V	23	Inservice training & education		Petersen Health Care Companies	0.00%	276	276	9
10	V	24	Travel & seminar		Petersen Health Care Companies	0.00%	939	939	10
11	V	25	Other admin. staff transport		Petersen Health Care Companies	0.00%	999	999	11
12	V	26	Insurance-property & liab.		Petersen Health Care Companies	0.00%	487	487	12
13	V	30	Depreciation		Petersen Health Care Companies	0.00%	3,128	3,128	13
14	Total			$ 68,884			$ 38,636	$ * (30,248)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Petersen Health Care, Inc.	0.00%	$ 6,462	$ 6,462	15
16	V	34	Rent-facility & grounds		Petersen Health Care, Inc.	0.00%	1,811	1,811	16
17	V	35	Rent-equipment & vehicles		Petersen Health Care, Inc.	0.00%	355	355	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 8,628	$ * 8,628	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
PROVIDER # 0046060
12/31/2003

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Courtyard Estates	Kewanee, IL	
Other Related Business Entities		
Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	330,038	1	2.50	Salary	$ 22,462	L17,C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,462		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Eastview Terrace
PROVIDER # 0046060
12/31/2003

Schedule 7A

VII Related Parties
C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient days	315,110	13	$ 2,200	$	20,079	$ 140	1
2	5	Utilities	Patient days	315,110	13	5,963		20,079	380	2
3	6	Maintenance supplies	Patient days	315,110	13	25,373		20,079	1,617	3
4	19	Professional services	Patient days	315,110	13	139,914		20,079	8,915	4
5	20	Dues, fees & subscriptions	Patient days	315,110	13	3,044		20,079	194	5
6	21	Clerical & general office	Patient days	315,110	13	165,031		20,079	10,516	6
7	22	Employee benefits	Patient days	315,110	13	173,328		20,079	11,045	7
8	23	Inservice training & education	Patient days	315,110	13	4,328		20,079	276	8
9	24	Travel & seminar	Patient days	315,110	13	14,743		20,079	939	9
10	25	Other admin. staff transport	Patient days	315,110	13	15,681		20,079	999	10
11	26	Insurance-property & liab.	Patient days	315,110	13	7,635		20,079	487	11
12	30	Depreciation	Patient days	315,110	13	49,093		20,079	3,128	12
13	32	Interest	Patient days	315,110	13	101,410		20,079	6,462	13
14	34	Rent-facility & grounds	Patient days	315,110	13	28,419		20,079	1,811	14
15	35	Rent-equipment & vehicles	Patient days	315,110	13	5,568		20,079	355	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 741,730	$		$ 47,264	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of Farmington		X	Car purchase	$499.00	03/28/01	$ 11,987	$ 12,151	04/27/03	0.0790	$ 1,954	1
2	LaSalle Bank		X	Mortgage	2044 + interest	08/31/02	1,887,097	1,854,100	08/31/07	varies	103,243	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Working capital	Interest only	08/31/03	150,000		08/31/04	varies	5,977	6
7												7
8												8
9	TOTAL Facility Related				$499.00		$ 2,049,084	$ 1,866,251			$ 111,174	9
	B. Non-Facility Related*											
10	Amortization of loan costs										4,333	10
11	Allocated from Mgnt. Co.										6,462	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 10,795	14
15	TOTALS (line 9+line14)						$ 2,049,084	$ 1,866,251			$ 121,969	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 10,245	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 10,598	2
3. Under or (over) accrual (line 2 minus line 1).		$ 353	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,506	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 10,859	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999	10,402	9
2000	10,589	10
2001	10,417	11
2002	10,598	12

2002 tax:	10,417
Increase (.8%)	1.008
2003 tax:	10,500
Use:	10,506

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eastview Terrace COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046060

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-01-202-037	Facility & Grounds	$ 10,597.16	$ 10,597.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,597.16	$ 10,597.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

See Accountants' Compilation Report

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,082 B. General Construction Type: Exterior Block Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	217,546	2000	$ 100,000	1
2					2
3	TOTALS	217,546		$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		2000	1976	$ 982,565	$ 25,194	39	$ 25,194	$	$ 100,776	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater			2000	4,800	600	7	686	86	2,401	9
10	Concrete Pad			2000	500	13	20	25	12	88	10
11	Painting Exterior Building			2000	2,480	286	5	496	210	1,736	11
12	Fence			2000	3,952	304	15	264	(40)	924	12
13	Asphalt Parking Lot			2000	2,370	182	15	158	(24)	553	13
14	Carpet			2000	503	63	7	72	9	252	14
15	Flooring			2001	72,265	1,853	39	1,853		4,632	15
16	Remodeling			2001	6,245	160	39	160		400	16
17	Roofing			2001	2,159	55	39	55		138	17
18	Roofing			2001	12,000	308	39	308		770	18
19	Replacement - Glass			2001	1,179	144	7	168	24	420	19
20	Medicare wing upgrade			2002	89,018	2,283	39	2,283		3,584	20
21	Roofing			2002	14,200	364	39	364		561	21
22	Flooring			2002	4,263	109	39	109		159	22
23	Architects Fee			2002	1,916	49	39	49		55	23
24	Wall hangings			2002	3,220	552	7	460	(92)	690	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,203,635	$ 32,519		$ 32,704	$ 185	$ 118,139	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 257,033	$ 35,950	$ 37,437	$ 1,487	5-7 years	$ 133,016	71
72	Current Year Purchases	16,165	9,257	1,175	(8,082)	5-7 years	1,175	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			3,128	3,128			74
75	TOTALS	$ 273,198	$ 45,207	$ 41,740	$ (3,467)		$ 134,191	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Plymouth Voyager 2000	2000	$ 42,307	$ 4,874	$ 8,461	$ 3,587	5	$ 33,844	76
77	Resident care	Malibu 2000	2001	11,054	2,122	2,211	89	5	5,527	77
78										78
79										79
80	TOTALS			$ 53,361	$ 6,996	$ 10,672	$ 3,676		$ 39,371	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,630,194	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,116	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 394	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 291,701	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocated from Management Company			1,811			5
6								6
7	TOTAL				$ 1,811 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,930 Description: Oxygen concentrators - $2,575; Allocated from Management Co. - $355
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10a, C3	hrs	$	3,661	$ 54,920	$	3,661	$ 54,920	1
2	Licensed Speech and Language Development Therapist	Ln 10a, C3	hrs		1,243	18,639		1,243	18,639	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a, C 2 & 3	hrs		5,756	86,340	1,888	5,756	88,228	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, C2	# of prescrpts				30,547		30,547	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	10,660	$ 159,899	$ 32,435	10,660	$ 192,334	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 260,285	$ 260,285	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	491,270	491,270	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,286	7,286	6
7	Other Prepaid Expenses	2,046	2,046	7
8	Accounts Receivable (owners or related parties)	687,672	687,672	8
9	Other(specify): See attached Schedule 17A	17,972	17,972	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,466,531	$ 1,466,531	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	1,203,635	1,203,635	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	326,559	326,559	16
17	Accumulated Depreciation (book methods)	(341,455)	(291,701)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill, net of amortization	320,669	320,669	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,609,408	$ 1,659,162	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,075,939	$ 3,125,693	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 199,718	$ 199,718	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,808	38,808	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,600	10,506	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	57,707	57,707	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 306,833	$ 306,739	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,151	12,151	39
40	Mortgage Payable	1,854,100	1,854,100	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,866,251	$ 1,866,251	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,173,084	$ 2,172,990	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 902,855	$ 952,703	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,075,939	$ 3,125,693	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Eastview Terrace
PROVIDER # 0046060
12/31/2003

Schedule 17A

XV. Balance Sheet
Line 9: Other Current Assets

	Operating	After Consolidation
Employee Advances	9,554	9,554
Assessments	8,418	8,418
Total	17,972	17,972

Line 36: Other Current Liabilities

Due to Patients	25,011	25,011
Accrued Vacation	21,013	21,013
Other Accrued Expenses	11,683	11,683
Total	57,707	57,707

See Accountants' Compilation Report

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 426,074	1
2	Restatements (describe):		2
3			3
4	**Prior Period adjustment**	(16,143)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 409,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	492,924	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 492,924	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 902,855	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,225,931	1
2	Discounts and Allowances for all Levels	53,573	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,279,504	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	154,033	6
7	Oxygen	2,067	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,100	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	50,269	14
15	Telephone, Television and Radio	752	15
16	Rental of Facility Space		16
17	Sale of Drugs	21,184	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	205	19
20	Radiology and X-Ray		20
21	Other Medical Services	750	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,160	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Income**	1,898	28
28a	**Miscellaneous Income**	8,827	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,725	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,519,489	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	485,054	31
32	Health Care	827,557	32
33	General Administration	419,411	33
	B. Capital Expense		
34	Ownership	209,330	34
	C. Ancillary Expense		
35	Special Cost Centers	50,385	35
36	Provider Participation Fee	34,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,026,565	40
41	**Income before Income Taxes (line 30 minus line 40)****	492,924	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 492,924	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity files as a cash basis tax payer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,091	2,211	$ 40,606	$ 18.37	1
2	Assistant Director of Nursing	979	979	15,062	15.39	2
3	Registered Nurses	3,918	4,007	70,082	17.49	3
4	Licensed Practical Nurses	10,501	10,772	162,003	15.04	4
5	Nurse Aides & Orderlies	29,392	30,001	266,849	8.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,073	2,137	18,073	8.46	9
10	Activity Assistants	16	16	132	8.25	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,014	13.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,817	15,339	115,697	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,234	2,234	24,782	11.09	17
18	Housekeepers	6,552	6,571	45,401	6.91	18
19	Laundry	4,678	4,708	32,357	6.87	19
20	Administrator	2,080	2,080	56,333	27.08	20
21	Assistant Administrator					21
22	Other Administrative	133	133	22,462	168.89	22
23	Office Manager					23
24	Clerical	3,130	3,130	37,915	12.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	175	175	1,426	8.15	31
32	Other Health Ca See Sch 20a	464	469	11,215	23.91	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,313	87,042	$ 948,409 *	$ 10.90	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,250	Ln 9, C 3	36
37	Medical Records Consultant	Monthly	542	Ln 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	550	Ln 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Rehabilitation Consultant	Monthly	2,183	Ln 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 17,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Eastview Terrace
Provider #: 0046060
01/01/03 to 12/31/03

Schedule 20A

Line 32 - Other Health Care:

Description	Hours Worked	Hours Paid	Salary & Wages	Ave. Hrly. Wage
Care Plan Coordinator	72	72	1,224	17.00
Corporate Nurse	392	397	9,991	25.17
	464	469	11,215	23.91

See Accountants' Compilation Report

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Wilson	Administrator	0%	$ 46,125
Cynthia Kesterson	Administrator	0%	10,208
Allocated from Management Co.			
Mark Petersen	Administrative	Sch 6A	22,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,795

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 68,884
TOTAL (agree to Schedule V, line 17, col. 3)	$ 68,884
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder Assoc.	Legal	$ 2,800
Altschuler, Melvoin & Glasser LLP	Accounting	3,755
American Express Tax & Business Services	Accounting	1,850
LTC Solutions	Computer consultation	1,320
ADP	Payroll services	5,578
R. Hadsell	Computer consultation	877
G. Wilson	Computer consultation	132
Ivans	Computer consultation	548
AOL	Internet services	75
Wilkerson Computer Services	Computer consultation	125
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,060

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,356
Unemployment Compensation Insurance	9,296
FICA Taxes	67,159
Employee Health Insurance	22,464
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	7,307
401(k) Management Fees	345
Employee Relations	7,932
Allocated from Management Co.	11,045
TOTAL (agree to Schedule V, line 22, col.8)	$ 152,904

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,272
Health Care Worker Background Check	
(Indicate # of checks performed 45)	538
Miscellaneous licenses	75
Miscellaneous dues and subscriptions	1,002
Allocated from Management Co.	194
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,081

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,620
Seminar Expense	441
Allocated from Management Co.	939
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,000

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Eastview Terrace
Provider #: 0046060
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	17,060
Allocated from Management Company	
Legal	1,225
Other	7,690
Total (agree to Schedule V, line 19, column 8)	25,975

See Accountants' Compilation Report

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Carpet & Chair Cleaning	1/15/00	$ 1,455	3	$ 243	$ 485	$ 485	$ 242	$	$	$	$	$
2	Hot Water Repair	4/12/00	2,366	3	395	788	788	395					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,821		$ 638	$ 1,273	$ 1,273	$ 637	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Eastview Terrace # 0046060 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,776** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,828**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **33,370**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet complete.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Eastview Terrace** **11:39 AM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-76,242	equal to	-76,242	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	121,969	equal to	121,969	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	10,859	equal to	10,859	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	85,116	equal to	85,116	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	1,811	equal to	1,811	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,930	equal to	2,930	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	161,787	equal to	161,787	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	32,435	equal to	32,435	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	485,054	equal to	485,054	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	827,557	equal to	827,557	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	419,411	equal to	419,411	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	209,330	equal to	209,330	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	50,385	equal to	50,385	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	34,828	equal to	34,828	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	556,028	equal to	567,243	-11,215	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	18,205	equal to	18,205	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	143,711	equal to	143,711	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	24,782	equal to	24,782	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	45,401	equal to	45,401	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	32,357	equal to	32,357	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	78,795	equal to	78,795	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	37,915	equal to	37,915	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	948,409	equal to	948,409	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	1,214	-1,214	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,250	< or = to	14,250	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,092	< or = to	3,275	-2,183	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	78,795	equal to	78,795	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	68,884	equal to	68,884	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	17,060	equal to	17,060	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	152,904	equal to	152,904	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,081	equal to	4,081	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,000	equal to	4,000	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	34,828	equal to	34,828	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	11,045	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,681	equal to	1,681	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-21,620	equal to	-21,620	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,866,251	equal to	1,866,251	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	10,506	equal to	10,506	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	100,000	equal to	100,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,203,635	equal to	1,203,635	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	326,559	equal to	326,559	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	291,701	equal to	291,701	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	902,855	equal to	902,855	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	492,924	equal to	492,924	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,075,939	equal to	3,075,939	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK
TO THE COST REPORT!! 11/4/2005 11:39:44 AM

HSA Number	4	Name	Eastview Terrace		
Cost report period	From:	01/01/03	To: 12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N			
Licensed bed days:	22,995	Occupancy:	20,079	Pct. of occupancy:	87.32%
Illinois Public Aid Support Rate		$			
Genl Services Salary/Wage:	246,251	Col 1, Line 8 ---Audit Adj:			
Genl Admin Salary/Wage	116,710	Col 1, Line 28 ---Audit Adj:	-22462		
Total Salary Wage	948,409	Col 1, Line 44 ---Audit Adj:	-22462		
Employee Benefits	152,904	Col 8, Line 22 ---Audit Adj:			
Total General Services:	454,458	Col 8, Line 8 ---Audit Adj:			
Total General Admin	380,248	Col 8, Line 28 ---Audit Adj:	-22462		

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amou by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$246,251
Divided by Total Wages (Column 1, Line 44	$925,947
General service wages as percent of total wages	26.5945%
Employee Benefits (Column 10, Line 22	$152,904
Allocation of Employee Benefits to General Services Costs	$40,664
Plus Total General Services (Column 10, Line 8	$454,458
New Total General Services Cost	$495,122

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$94,248
Divided by Total Wages (Column 1, Line 45	$925,947
General administration wages as a percent of total wages	10.1786%
Employee Benefits (Column 10, Line 22	$152,904
Allocation of Emplayee Benefits to General Admin. Cost	$15,563
Plus Total General Administration (Column 10, Line 2	$357,786
Minus Total Fringe (Column 10, Line 2:	$152,904
New Total General Administration Cos	$220,445

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (fron Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$495,122	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$495,122

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$220,445	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$220,445

3 Total Updated Support Costs (1 + 2 $715,567

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $34.88

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$715,567
Total Patient Days (Cost Report	20,079
Support Costs per Dien	$35.64

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	22,995
Multiplied by	0.93
	21,385
Minus total Patient Day:	20,079
	1,306
One-third of difference	435
Plus Total Patient Day	20,079
Adjusted Occupancy	20,514
Total Support Costs (Step II, C, 3, above	$715,567
Divided by Adjusted Occupany	20514
Support Costs Per Dien	$34.88

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$37.33
Minus Support Costs Per Dier	$34.88
Difference	$2.45
Multiply the Difference by	0.5
One-Half of the Difference	$1.23
Plus Support Costs Per Dier	$34.88
Support Rate if costs are between 35th and 75th percentile	36.11

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$37.33
Minus Support Costs Per Dier	$34.88
Difference	$2.45
Multiply the Difference by	0.5
One-Half of the Difference	$1.23
Compare one-half the difference to the profit ceiling for your HSA in Table II anc	2.83
Enter the Lower of the Two Amounts	$1.230
Plus Support Costs Per Dier	$34.88
Support Rate if support costs less than 35th percentile	$36.11

D. **YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc** **$36.11**

75th Percentile is	$37.33
35th Percentile is	$31.77

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 11:39:44 AM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Eastview Terrace** ID: **0046060**

HSA No.: ? Own or Rent? (O or R) ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	63	Total Patient Days	20,079
Begin	**01/01/03**	Licensed Bed Days:	22,995	% Occupied	87.32%
End	**12/31/03**			Capital Days	21,385

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1980
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	1203635
2. Total licensed beds from cost report Page 2, Line 7, column 3	63
3. Line 1 divided by Line 2	$19,105
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:	
1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	21,385
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A
Capital Days The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)	
1. Total Patient Days	20,079
2. Total Licensed Bed Days * .93	21385
3. Capital Days (higher of Line 1 or Line 2)	21,385
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	76	982565	74674940	12	97	0	0	0	12B
2	2	85	0	0	12	98	0	0	0	12B
3	3	0	0	0	12	99	0	0	0	12C
4	4	0	0	0	12	100	0	0	0	12C
5	5	0	0	0	12	101	0	0	0	12C
6	6	100	4800	480000	12	102	0	0	0	12C
7	7	100	500	50000	12	103	0	0	0	12C
8	8	100	2480	248000	12	104	0	0	0	12C
9	9	100	3952	395200	12	105	0	0	0	12C
10	10	100	2370	237000	12	106	0	0	0	12C
11	11	100	503	50300	12	107	0	0	0	12C
12	12	101	72265	7298765	12	108	0	0	0	12C
13	13	101	6245	630745	12	109	0	0	0	12C
14	14	101	2159	218059	12	110	0	0	0	12C
15	15	101	12000	1212000	12	111	0	0	0	12C
16	16	101	1179	119079	12	112	0	0	0	12C
17	17	102	89018	9079836	12	113	0	0	0	12C
18	18	102	14200	1448400	12	114	0	0	0	12C
19	19	102	4263	434826	12	115	0	0	0	12C
20	20	102	1916	195432	12	116	0	0	0	12C
21	21	102	3220	328440	12	117	0	0	0	12C
22	22	0	0	0	12	118	0	0	0	12C
23	23	0	0	0	12	119	0	0	0	12C
24	24	0	0	0	12	120	0	0	0	12C
25	25	0	0	0	12	121	0	0	0	12C
26	26	0	0	0	12	122	0	0	0	12C
27	27	0	0	0	12	123	0	0	0	12C
28	28	0	0	0	12	124	0	0	0	12C
29	29	0	0	0	12	125	0	0	0	12C
30	30	0	0	0	12	126	0	0	0	12C
31	31	0	0	0	12	127	0	0	0	12C
32	32	0	0	0	12	128	0	0	0	12C
33	33	0	0	0	12	129	0	0	0	12C
34	34	0	0	0	12A	130	0	0	0	12C
35	35	0	0	0	12A	131	0	0	0	12D
36	36	0	0	0	12A	132	0	0	0	12D
37	37	0	0	0	12A	133	0	0	0	12D
38	38	0	0	0	12A	134	0	0	0	12D
39	39	0	0	0	12A	135	0	0	0	12D
40	40	0	0	0	12A	136	0	0	0	12D
41	41	0	0	0	12A	137	0	0	0	12D
42	42	0	0	0	12A	138	0	0	0	12D
43	43	0	0	0	12A	139	0	0	0	12D
44	44	0	0	0	12A	140	0	0	0	12D
45	45	0	0	0	12A	141	0	0	0	12D
46	46	0	0	0	12A	142	0	0	0	12D
47	47	0	0	0	12A	143	0	0	0	12D
48	48	0	0	0	12A	144	0	0	0	12D
49	49	0	0	0	12A	145	0	0	0	12D
50	50	0	0	0	12A	146	0	0	0	12D
51	51	0	0	0	12A	147	0	0	0	12D
52	52	0	0	0	12A	148	0	0	0	12D
53	53	0	0	0	12A	149	0	0	0	12D
54	54	0	0	0	12A	150	0	0	0	12D
55	55	0	0	0	12A	151	0	0	0	12D
56	56	0	0	0	12A	152	0	0	0	12D
57	57	0	0	0	12A	153	0	0	0	12D
58	58	0	0	0	12A	154	0	0	0	12D
59	59	0	0	0	12A	155	0	0	0	12D
60	60	0	0	0	12A	156	0	0	0	12D
61	61	0	0	0	12A	157	0	0	0	12D
62	62	0	0	0	12A	158	0	0	0	12D
63	63	0	0	0	12A	159	0	0	0	12D
64	64	0	0	0	12A	160	0	0	0	12D
65	65	0	0	0	12A	161	0	0	0	12D
66	66	0	0	0	12A	162	0	0	0	12D
67	67	0	0	0	12B					
68	68	0	0	0	12B					
69	69	0	0	0	12B					
70	70	0	0	0	12B					
71	71	0	0	0	12B					
72	72	0	0	0	12B					
73	73	0	0	0	12B					
74	74	0	0	0	12B					
75	75	0	0	0	12B					
76	76	0	0	0	12B					
77	77	0	0	0	12B					
78	78	0	0	0	12B					
79	79	0	0	0	12B					
80	80	0	0	0	12B					
81	81	0	0	0	12B					
82	82	0	0	0	12B					
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88	88	0	0	0	12B					
89	89	0	0	0	12B					
90	90	0	0	0	12B					
91	91	0	0	0	12B					
92	92	0	0	0	12B					
93	93	0	0	0	12B					
94	94	0	0	0	12B					
95	95	0	0	0	12B					
96	96	0	0	0	12B					

Base year:
Total of Column C/Total of Column B = Base Year

97101022 1203635 80.67314593

Base Year = 1980

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	143,711	13,913	1,214	158,838	0	158,838	140	158,978
2. Food Purchase	0	106,746	0	106,746	0	106,746	-33,370	73,376
3. Housekeeping	45,401	18,093	0	63,494	0	63,494	0	63,494
4. Laundry	32,357	11,393	0	43,750	0	43,750	0	43,750
5. Heat and Other Utilities	0	0	54,051	54,051	0	54,051	380	54,431
6. Maintenance	24,782	23,145	10,248	58,175	0	58,175	2,254	60,429
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	246,251	173,290	65,513	485,054	0	485,054	-30,596	454,458
9. Medical Director	0	0	14,250	14,250	0	14,250	0	14,250
10. Nursing & Medical Records	567,243	61,133	3,275	631,651	0	631,651	0	631,651
10a. Therapy	0	1,888	159,899	161,787	0	161,787	0	161,787
11. Activities	18,205	1,627	0	19,832	0	19,832	0	19,832
12. Social Services	0	37	0	37	0	37	0	37
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	585,448	64,685	177,424	827,557	0	827,557	0	827,557
17. Administrative	78,795	0	68,884	147,679	0	147,679	-68,884	78,795
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	17,060	17,060	0	17,060	8,915	25,975
20. Fees, Subscriptions & Promotion	0	0	3,887	3,887	0	3,887	194	4,081
21. Clerical & General Office	37,915	4,395	11,994	54,304	0	54,304	6,866	61,170
22. Employee Benefits & Payroll	0	0	141,859	141,859	0	141,859	11,045	152,904
23. Inservice Training & Education	0	0	2,455	2,455	0	2,455	276	2,731
24. Travel and Seminar	0	0	3,061	3,061	0	3,061	939	4,000
25. Other Admin. Staff Trans	0	0	2,963	2,963	0	2,963	999	3,962
26. Insurance-Prop.Liab.Malpractice	0	0	46,143	46,143	0	46,143	487	46,630
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	116,710	4,395	298,306	419,411	0	419,411	-39,163	380,248
29. Total General Administrative	948,409	242,370	541,243	1,732,022	0	1,732,022	-69,759	1,662,263
30. Depreciation	0	0	84,722	84,722	0	84,722	394	85,116
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	111,174	111,174	0	111,174	10,795	121,969
33. Real Estate	0	0	10,859	10,859	0	10,859	0	10,859
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,811	1,811
35. Rent - Equipment & Vehicles	0	0	2,575	2,575	0	2,575	355	2,930
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	209,330	209,330	0	209,330	13,355	222,685
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	30,547	0	30,547	0	30,547	0	30,547
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	34,828	34,828	0	34,828	0	34,828
43. Other (specify):*	0	0	19,838	19,838	0	19,838	-19,838	0
44. Total Special Cost Ce	0	30,547	54,666	85,213	0	85,213	-19,838	65,375
45. Grand Total	948,409	272,917	805,239	2,026,565	0	2,026,565	-76,242	1,950,323

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	260,285	260,285
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	491,270	491,270
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,286	7,286
7. Other Prepaid Expenses	2,046	2,046
8. Accounts Receivable-Owner/Related Party	687,672	687,672
9. Other (specify):	17,972	17,972
10. Total current assets	1,466,531	1,466,531
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	100,000	100,000
14. Buildings, at Historical Cost	1,203,635	1,203,635
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	326,559	326,559
17. Accumulated Depreciation (book methods)	-341,455	-291,701
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	320,669	320,669
24. Total Long-Term Assets	1,609,408	1,659,162
25. Total Assets	3,075,939	3,125,693
CURRENT LIABILITIES		
26. Accounts Payable	199,718	199,718
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	38,808	38,808
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	10,600	10,506
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	57,707	57,707
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	306,833	306,739
LONG TERM LIABILITES		
39.Long-Term Notes Payable	12,151	12,151
40.Mortgage Payable	1,854,100	1,854,100
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,866,251	1,866,251
46.Total Liabilities	2,173,084	2,172,990
47.Total Equity	902,855	952,703
48.Total Liabilities and Equity	3,075,939	3,125,693

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,225,931
2. Discounts and Allowances for all Levels	53,573
Subtotal - Inpatient Care	2,279,504
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	154,033
7. Oxygen	2,067
Subtotal - Anciliary Revenue	156,100
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	50,269
15. Telephone, Television, and Radio	752
16. Rental of Facility Space	0
17. Sale of Drugs	21,184
18. Sale of Supplies to Non-Patients	0
19. Laboratory	205
20. Radiologyand X-Ray	0
21. Other Medical Services	750
22. Laundry	0
Subtotal - Other Operating Revenue	73,160
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	1,898
28. Other Revenue (specify):	8,827
Subtotal - Other Revenue	10,725
30. Total Revenue	2,519,489
31. General Services	485,054
32. Health Care	827,557
33. General Administration	419,411
34. Ownership	209,330
35. Special Cost Centers	50,385
35. Provider Participation Fee	34,828
37. Other	0
40. Total Expenses	2,026,565
41. Income Before Income Taxes	492,924
42. Income Taxes	0
43. Net Income or Loss for the Year	492,924

Page	
1	
2	
3	
4	
5	
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23	Provider Participation fee is linked from page 4